State of California -- Health and Welfare Agency

Department of Alcohol and Drug Programs

DRUG/MEDI-CAL ELIGIBILITY WORKSHEET

CONFIDENTIAL CLIENT INFORMATION
42 CFR Part 2 Sections 2.12 and 2.13

ALCOHOL/DRUG TREATMENT SERVICES

D-

PROVIDER NAME | PROVIDER CODE | CLAIM FOR: MO YR | PROGRAM CODE | MODE OF SERVICE

Page_____ of _____

LINE NO.	CLIENT NAME	CLIENT RECORD NO.	SOCIAL SECURITY NUMBER	YEAR OF BIRTH	SEX	RACE/ETHN.	DSM III DIAGNOSTIC CODE	MO/YR OF SERVICE	TREATMENT DATES FIRST	TREATMENT DATES LAST	DISCHARGE	SFC	UNITS OF SERVICE	DOLLARS CLAIMED Dollars	DOLLARS CLAIMED Cents	GOOD CAUSE	DUPLICATE OVERRIDE	COUNSELOR INDICATOR	LINE NO.
01															.				01
02															.				02
03															.				03
04															.				04
05															.				05
06															.				06
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11															.				11
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13															.				13
14															.				14
15															.				15
															.	PAGE TOTALS			
															.	GRAND TOTALS			

The services listed on this form have been personally provided to the patient by the provider or under his direction by another person eligible under the Medi-Cal Program to provide such services, and such person(s) are designated on this form. The services were, to the best of the provider's knowledge, medically indicated and necessary to the health of the patient. The provider understands that payment of this claim will be from Federal and/or State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and/or State laws. The provider agrees to keep for a minimum period of three years from the date of service all records which are necessary to disclose fully the extent of services furnished to the patient. The provider agrees to furnish these records and any information regarding payments claimed for providing the services, on request, to California Department of Health Services; Medi-Cal Fraud Unit, California Department of Justice; Medi-Cal Audits Project, Office of State Controller; U. S. Department of Health and Human Services, or their duly authorized representatives. Medical care services are offered and provided without discrimination based on race, religion, color, national or ethnic origin

Signature_____ **Phone (**_____**)**_____

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